Appel Foot & Ankle Center Patient Registration

320 Beverly Rancocas Rd, Ste 3M, Willingboro, NJ 08046 609.835.2676

Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____

Sex: Male/ Female / Undifferentiated

Address: _____

City: _____ State: _____ Zip: _____

Phone #: (Home): _____ (Cell): _____
(Work): _____
Personal E-mail: _____

Primary Care Physician: _____

Primary Insurance:

Plan Name: _____ Policy #: _____

Relationship to Main Policy Holder: [ ] Self [ ] Spouse [ ] Child

If not Self what is Main Policy Holder's: **Name**: _____
DOB: _____/_____/_____

Secondary Insurance: (If applicable)

Plan Name: _____ Policy #:_____

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Employer: _____ Occupation: _____

Shoe Size: _____ Height: ___ft ___in Weight: _____lb

By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian: _____ Date: _____

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MEDICAL HISTORY FORM

ALLERGIES: [ ] Penicillin [ ] Sulfa Drugs [ ] Adhesive/Tape [ ] Latex [ ] Other: _____
[ ] No Known Allergies

Medications: Please provide list or write below: ☐ No Prescribed Medications

Medication Name	Dosage	Medication Name	Dosage

TOBACCO USE: [ ] Current Smoker [ ] Former [ ] Never

ALCOHOL USE: [ ] None [ ] Occasional [ ] Light [ ] Heavy

RECREATIONAL DRUG USE [ ] Yes [ ] No

PAST SURGERIES:
[ ]Knee [ ] Hip [ ] Back Surgery [ ] Hernia Repair [ ] Heart Surgery [ ] Appendix [ ] Hysterectomy [ ] Foot/Ankle Surgery [ ] Transplants [ ] Other:_____

MEDICAL CONDITION\S:

[ ] Diabetes [ ] Arthritis [ ] Asthma [ ] Anemia [ ] Atrial Fibrillation [ ] Eczema/Psoriasis

[ ] Cancer [ ] Vitamin D deficiency [ ] Liver Disease [ ] Kidney Disease [ ] Blood Clots

[ ] Sickle Cell [ ] Heart Disease [ ] Peripheral Vascular Disease [ ] Rheumatoid Arthritis

[ ] Stroke [ ] HIV/AIDS [ ] Tuberculosis [ ] Thyroid Disease [ ] Anxiety/Depression

[ ] Mental Illness [ ] Neurologic Condition [ ] Gout [ ] High Blood Pressure [ ] GERD

[ ] Other (please specify): _____

FAMILY HISTORY:
[ ] Diabetes [ ] Heart Disease [ ] (Cancer specify below) [ ] Thyroid [ ] High Blood Pressure [ ] High Cholesterol [ ] Other: _____

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Appel Foot & Ankle Center, LLC Financial Policy:

Payment for services are required at the time of service; therefore, at the time of your appointment. We accept payment in the form of cash, credit or debit card, or check. If you have insurance coverage with which we do not participate, we will process a claim after you have paid in full any balances due. Returned checks are subject to additional collection fees, including insufficient funds fees. Balances older than 90 days are forwarded to a collection agency with additional fees.

No Show Fee: If you missed your appointment without 24 hour notice subject to $50.00 fee
Insufficient Funds (Check Bounce) Fee: $50.00

Medicare Patients are responsible for 20% coinsurance and your annual deductible

I authorize APPEL FOOT & ANKLE CENTER, LLC to submit all insurance claims on my behalf. I understand that I am responsible for all services not covered by insurance.

Appel Foot & Ankle Center, LLC does not bill injury or work related cases. We will not send your claims if you have a workers comp, slip and fall or another accident. You will be responsible for all charges.

PARTICIPATING INSURANCES AND MEDICARE ASSIGNMENT: I authorize payment made on my behalf to APPEL FOOT & ANKLE CENTER, LLC for any services performed. I authorize the release of any medical information held by APPEL FOOT & ANKLE CENTER, LLC to the healthcare financing administration and its agents in order to process my claims.

I, the below signer, hereby give permission to Appel Foot & Ankle Center, LLC to administer, treat, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the lower extremity condition. I also hereby assign Appel Foot & Ankle Center, LLC and Dr. Douglas Appel all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account and a collection agency will be employed to enforce such. Furthermore, I have read and signed the financial responsibility form and understand the financial policy of Appel Foot & Ankle Center, LLC. I understand this is a lifetime signature. It is understood that all durable medical equipment (DME) and products including, but not limited to creams, lotions, orthotics, arch supports, braces, pads, diabetic shoes, surgical shoes, crutches, can be purchased via an outside profession vendor. The products and in office dispensing are for the convenience of the patient; therefore, financial responsibility will be solely on the patient. All payments for such services or devices are due upon the receipt of service or item unless other arrangements have been made in advance.

Signature of responsible party: _____ Date: _____

Printed name: _____

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HIPAA NOTIFICATION FORM

I. DESIGNATION OF RELATIVES, CLOSE FRIENDS & OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such a person Is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare

Print Name_____DOB_____ Phone: _____

Print Name_____DOB_____ Phone: _____

III. REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Is cell phone number [___] OK to leave a detailed message

Is home phone number [___] OK to leave a detailed message

IV. THE FOLLOWING PERSON(S) ARE AUTHORIZED TO RECEIVE MY PATIENT HEALTH INFORMATION (PHI)

Print Name_____ Print Name_____

V. The HIPAA Privacy rule requires healthcare providers to make reasonable steps to limit the use or disclosure of and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary healthcare activities related to providing patient treatment, obtaining payment for its services, or for its internal operations. Also, the Practice does not have to account disclosures for which I have executed an Authorization permitting disclosures of my PHI.

a. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.
b. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."
c. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
d. If you request it, a copy of information described in this form can be obtained at the front desk.
e. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
f. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

E-Prescribing Consent:

I, the below signer, agree and consent that Appel Foot & Ankle Center can request and use your pharmacy and medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ _____ _____

Name of Patient (Printed) **Signature** Date